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RR RUEHCHI RUEHDT RUEHHM RUEHLN RUEHMA RUEHNH RUEHPB RUEHPOD
DE RUEHGO #0282/01 1141022
ZNR UUUUU ZZH
R 231022Z APR 08 ZDK TO ALL CTG NUM SVCS
FM AMEMBASSY RANGOON
TO RUEHC/SECSTATE WASHDC 7421
RUCNASE/ASEAN MEMBER COLLECTIVE
RUEHZN/ENVIRONMENT SCIENCE COLLECTIVE
RUEHBJ/AMEMBASSY BEIJING 1821
RUEHBY/AMEMBASSY CANBERRA 1072
RUEHKA/AMEMBASSY DHAKA 4830
RUEHLO/AMEMBASSY LONDON 2019
RUEHNE/AMEMBASSY NEW DELHI 4620
RUEHUL/AMEMBASSY SEOUL 8160
RUEHTC/AMEMBASSY THE HAGUE 0673
RUEHKO/AMEMBASSY TOKYO 5721
RUEHRO/AMEMBASSY ROME 0157
RUEHFR/AMEMBASSY PARIS 0576
RUEHCN/AMCONSUL CHENGDU 1424
RUEHCHI/AMCONSUL CHIANG MAI 1514
RUEHCI/AMCONSUL KOLKATA 0282
RUEAUSA/DEPT OF HHS WASHDC
RHHMUNA/CDR USPACOM HONOLULU HI
RUEHPPH/CDC ATLANTA GA
RUCLRFA/USDA WASHDC
RUEHRC/USDA FAS WASHDC
RHEHNSC/NSC WASHDC
RUCNDT/USMISSION USUN NEW YORK 1475
RUEKJCS/SECDEF WASHDC
RUEHBS/USEU BRUSSELS
RUEKJCS/JOINT STAFF WASHDC

UNCLAS SECTION 01 OF 03 RANGOON 000282

SENSITIVE
SIPDIS

DEPT FOR EAP/EX; EAP/MLS; EAP/EP; EAP/PD
DEPT FOR OES/STC/MGOLDBERG AND PBATES; OES/PCI/ASTEWART;
OES/IHA/DSINGER AND NCOMELLA
DEPT PASS TO USAID/ANE/CLEMENTS AND GH/CARROLL
CDC ATLANTA FOR COGH SDOWELL and NCID/IB AMOEN
USDA FOR OSEC AND APHIS
USDA FOR FAS/DLP/HWETZEL AND FAS/ICD/LAIDIG
USDA/FAS FOR FAA/YOUNG, MOLSTAD, ICD/PETTRIE, ROSENBLUM
DOD FOR OSD/ISA/AP FOR LEW STERN
PARIS FOR FAS/AG MINISTER COUNSELOR/OIE
ROME FOR FAO
BANGKOK FOR REO OFFICE, USAID/RDMA HEALTH OFFICE - JMACARTHUR,
CBOWES
TOKYO FOR HEALTH OFFICER
PACOM FOR FPA

E.O. 12958:N/A
TAGS: [ECON](#) [TBIO](#) [EAID](#) [SOCI](#) [PGOV](#) [AMED](#) [BM](#)
SUBJECT: BURMA: COMBATING MDR-TB IN RANGOON AND MANDALAY

REF: A) RANGOON 278 B) 07 RANGOON 1120 C) 07 RANGOON 1027

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11. (SBU) Summary. Tuberculosis is a growing concern in Burma, with the Ministry of Health ranking it as the second priority disease after HIV/AIDS. As the TB prevalence rate increases throughout the country, the risk of multi drug resistant (MDR) and extensively drug resistant (XDR) TB also increases. Recognizing that MDR-TB rates are likely three times higher than previous estimates - 4.2 percent and 15.5 percent MDR among new and previously treated cases in 2003 - the GOB plans to launch a three-year MDR-TB treatment pilot program in 2008. Using second-line TB drugs procured from the Green Light Committee, the National TB Program (NTP) will collaborate with the WHO and MSF-Holland to provide treatment to 100 patients in Rangoon and Mandalay in 2008 and extend the program to an additional 175 patients in mid-2009. Additionally, in the next few weeks the GOB plans to establish a second-line treatment protocol based on the results of 100 Category II TB failures analyzed in Belgium. If the

pilot program is successful, the GOB and WHO plan to expand the program to the national level in the next five years. End Summary.

Growing Concern About MDR-TB

¶2. (SBU) Burma is one of 22 TB high burden countries in the world. As the rate of TB prevalence increases throughout Burma, so does the rate of MDR-TB. A 2003 WHO study on National Drug Resistance showed that 4 percent of new TB cases and 15.5 percent of previously treated TB cases were multi drug resistant - these figures are the highest in Southeast Asia (Ref B). A 2006 MDR study in Rangoon showed higher MDR-TB prevalence rates - 4.2 percent among new cases and 18.8 percent among previously treated cases, which indicate higher rates at the national level. WHO TB officer Dr. Hans Kluge acknowledged that the true TB burden in Burma remains unknown but that the TB prevalence rate, and thus the rate of MDR-TB rate, are likely to be three times higher than previous estimates (Ref C). While health officials cannot pinpoint exactly why the rate of MDR-TB in Burma is so high, they note that both the availability of inferior TB drugs on the local market, as well as higher default treatment rates, play a role in creating new MDR-TB cases. The NTP Reference Lab, under the guidance of Lab Director Dr. Ti Ti, is currently conducting the Second National Drug Resistance survey. Results are expected by late 2008.

¶3. (SBU) In addition to the National Drug Resistance Survey, the Burmese Government, working with the WHO, sent samples from 100 Category II TB failures to the National Reference Lab in Antwerp for analysis in 2007. While the results of the survey are not yet finalized, Dr. Kluge and Dr. Win Maung from the NTP informed us that almost all of the 100 cases were resistant to first-line TB drugs.

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Additionally, the Antwerp lab confirmed that one of the cases was XDR-TB, which proves that XDR-TB does exist in Burma, albeit at an unknown magnitude. The GOB and WHO will use the results of the Antwerp study to establish a protocol of second-line drugs to treat MDR-TB cases. According to Kluge, the Ministry of Health should approve the protocol by the end of April.

GOB Efforts to Combat MDR-TB

¶4. (SBU) WHO and NTP officials agree that MDR and XDR-TB are serious threats not just to Burma, but also the region, as Burmese migrants with TB travel to neighboring countries to find work. Indeed, a MSF-France clinic in Mae Sot, Thailand diagnosed several cases of MDR and XDR-TB among Burmese migrants working in Thailand in 2007 (Ref B). Thus, MDR and XDR-TB cases in Burma potentially pose serious threats to the health of the region, Dr. Kluge declared. The GOB recognizes the seriousness of TB, Dr. Kluge stated. Although healthcare for Burmese citizens remains woefully under funded, the GOB has increased its TB budget significantly - from \$14,500 in 1995 to \$400,000 in FY08 - but the budget is still far short of what is needed. In 2006, the GOB established the National Drug Resistant TB Committee, comprised of officials the NTP, Food and Drug Administration, National Health Lab, WHO, PSI, and MSF-Holland. This committee created the National Response to MDR-TB in Burma and helped establish a pilot protect to treat MDR-TB, which will begin in late 2008. The GOB has also taken steps to improve the NTP in recent years, recognizing that a strong DOTS program is key to preventing MDR and XDR-TB. In the past two years, the Ministry of Health created 13 additional posts to strengthen the TB control activities at the State and Division level. It also created a new MDR-TB consultant position to work with the WHO and coordinate activities and draft the MDR-TB operational plan.

DOTS Plus Pilot Project

¶5. (SBU) The GOB has done more than just establish MDR-TB treatment protocols, Dr. Kluge emphasized. In 2007, the NTP and the WHO jointly applied for a grant from the Greenlight Committee to fund a pilot project to treat MDR-TB. The Greenlight Committee approved the grant in late 2007 and will provide second-line drugs

for 275 MDR-TB patients over three years. Second-line TB drugs are much costlier than the drugs for first-line treatment and cost an average of \$3,000 per patient. To prepare for the pilot, the NTP and WHO have established a national second-line drug treatment protocol based on the results of the 100 Category II TB failures; the National TB Committee should approve the protocol by the end of April. Once the protocol is approved, the NTP and WHO will order

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the drugs, which should arrive within six months.

¶16. (SBU) NTP, in collaboration with the WHO and MSF-Holland, plan to launch the MDR-TB pilot program by October 2008. Under the program, the NTP will provide second-line drugs to 100 MDR patients in five townships in Rangoon and Mandalay during the first year and expand the program to an additional 175 patients by mid-2009. During the first year, the National TB Committee will select 25 MDR-TB patients from Mandalay and 50 patients from Rangoon to receive the drug protocol at either the Pathengyi TB Hospital or Aung San TB Hospital. MSF-Holland will also select 25 of its patients from Rangoon, who will be treated at Aung San Hospital. MDR-TB treatment takes substantially longer than normal TB treatment - 18 to 24 months compared to six to nine months. During the year, patients will spend the first four months at either of the two TB hospitals, where they will be monitored daily. For the remaining months, patients will receive daily outpatient care. Because the MDR-TB treatment is so time consuming, the NTP will rely on community volunteers and health workers from Population Services International (PSI), MSF-Holland, and World Vision to monitor patients' treatment. NTP officials will be responsible for the monitoring and evaluation of the program. It will be challenging, Kluge declared, but he believes the NTP is committed to treating MDR-TB and containing the problem within Burma.

Comment

¶17. (SBU) The Ministry of Health is not the obstacle to tackling Burma's TB problem. It is staffed with low-paid but dedicated civil servants who comprehend the growing problem and are trying their best to treat it with the minimal resources the senior generals allocate to them. While the national program and private sector appear to be handling the current TB case load, an increasing number of MDR-TB cases will overburden the program's capacity. This pilot program will enable the NTP and Ministry of Health to show that they can handle more difficult TB cases. However, Burma also needs to focus on preventing MDR-TB as well as treating it. The best way to prevent MDR-TB and XDR-TB outbreaks is to strengthen the existing NTP and DOTS program and promote educational outreach to ensure that new cases are treated properly. Burma's growing TB problem is a danger to the region, and eventually to the world, if it cannot be contained soon.

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